

**INITIAL QUESTIONNAIRE AND STATEMENT OF APPLICANT
FOR DISABILITY RETIREMENT**

CO-1050 REV 9/2015

STATE OF CONNECTICUT
OFFICE OF THE STATE COMPTROLLER
RETIREMENT SERVICES DIVISION
55 ELM STREET
HARTFORD, CT 06106

PRINT OR TYPE

MEMBER'S NAME (Last)	First Name	M.I.	MEMBER ID	RETIREMENT DATE
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PART I - SOCIAL SECURITY INFORMATION

A. HAVE YOU RECEIVED ANY PRIMARY AND/OR FAMILY SOCIAL SECURITY BENEFITS, INCLUDING A SOCIAL SECURITY DISABILITY AWARD, ON ACCOUNT OF YOUR OWN EARNINGS HISTORY SINCE YOUR REQUESTED RETIREMENT DATE? ☐ YES ☐ NO

IF YES, TYPE(S) OF BENEFIT(S): ☐ PRIMARY ☐ FAMILY CLASSIFICATION: ☐ REGULAR ☐ DISABILITY

IF YES, DATE BENEFIT COMMENCED: _____

AMOUNT OF BENEFIT YOU RECEIVE MONTHLY: _____

B. HAVE YOU APPLIED FOR SOCIAL SECURITY BENEFITS? ☐ YES ☐ NO

IF YES, YOU MUST SEND US A COPY OF THE SOCIAL SECURITY ADMINISTRATION'S NOTIFICATION OF APPROVAL AS SOON AS YOU RECEIVE IT.

C. ARE YOU RECEIVING ANY SOCIAL SECURITY BENEFITS AS A RESULT OF ANOTHER PERSON'S EARNINGS HISTORY? ☐ YES ☐ NO

IF YES, PLEASE INDICATE THE NAME, SOCIAL SECURITY NUMBER AND RELATIONSHIP OF THE PERSON TO YOU.

NAME	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU
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DATE SOCIAL SECURITY BENEFITS COMMENCED: _____

AMOUNT OF SUCH SOCIAL SECURITY BENEFITS YOU RECEIVE MONTHLY: _____

D. PLEASE ATTACH COPY OF THE SOCIAL SECURITY ADMINISTRATOR'S NOTIFICATION OF THE AMOUNT OF YOUR BENEFIT AND THE EFFECTIVE DATE.

COMMENTS _____

PART II - WORKERS' COMPENSATION OR DISABILITY COMPENSATION

A. HAVE YOU RECEIVED ANY WORKERS' COMPENSATION OR DISABILITY COMPENSATION (C.G.S. 5-142(a)) SINCE YOUR REQUESTED RETIREMENT DATE?

☐ YES ☐ NO

IF YES, THE TYPE OF COMPENSATION YOU HAVE RECEIVED IS IMPORTANT IN ADDITION TO THE PERIODS OF TIME AND AMOUNTS PAID. PLEASE INDICATE TYPE OF BENEFIT YOU ARE NOW RECEIVING (CHECK ONE)

☐ 5-142(a) AT 100% ☐ 5-142(a) AT 50% ☐ TEMPORARY TOTAL ☐ TEMPORARY PARTIAL

☐ PERMANENT PARTIAL (SPECIFIC) ☐ ADDITIONAL BENEFITS AFTER SPECIFIC AT COMMISSIONER'S DISCRETION ☐ SETTLEMENT

AMOUNT RECEIVED _____ ☐ WEEKLY ☐ BI-WEEKLY ☐ MONTHLY

WHEN DID THIS BENEFIT BEGIN? _____

WHEN DO YOU EXPECT THIS BENEFIT TO END? _____

B. IF YOU HAVE HAD A CHANGE IN THE TYPE OF COMPENSATION BENEFIT YOU RECEIVED SINCE THE EFFECTIVE DATE OF YOUR RETIREMENT, PLEASE EXPLAIN:

C. PLEASE ATTACH A COPY OF ANY COMPENSATION AGREEMENTS OR SETTLEMENTS VERIFYING THE ABOVE INFORMATION.

COMMENTS _____

PART III - MEMBER'S STATEMENT

I UNDERSTAND THAT THE AMOUNT OF DISABILITY RETIREMENT INCOME TO WHICH I AM ENTITLED FROM THE STATE EMPLOYEES RETIREMENT SYSTEM IS, IN PART, DETERMINED BY MY RECEIPT OF SOCIAL SECURITY BENEFITS, WORKERS' COMPENSATION AND DISABILITY COMPENSATION. IN THE FUTURE, ANY OUTSIDE EARNINGS MAY ALSO AFFECT THE AMOUNT OF MY DISABILITY RETIREMENT. THEREFORE, I PROMISE TO DILIGENTLY NOTIFY THE RETIREMENT SERVICES DIVISION IN THE EVENT OF A COMMENCEMENT OR CHANGE IN INCOME FROM THESE SOURCES.

MEMBER'S SIGNATURE	DATE
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